U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 28 May 2004

CASE NO. 2003-BLA-06083

In the Matter of

LEO A. CHEMELLI,
Claimant

v.

CANTERBURY COAL COMPANY,
Employer

and

OLD REPUBLIC INSURANCE COMPANY,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Heath M. Long, Esquire
For the Claimant

Toni Minner, Esquire
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS[1]

This proceeding arises from a miner's duplicate claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*., as amended ("Act"), filed April 5, 2002. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

[1] Sections 718.2 and 725.2(c) address the applicability of the new regulations to pending claims.

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal worker's pneumoconiosis" ["CWP"]) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The claimant filed the instant claim, his fourth claim for benefits, on April 5, 2002. (Director's Exhibit "DX" 4). The record of the claimant's previous claims are contained in DX 1 and 2. The miner filed his first claim for federal black lung benefits on August 2, 1988 and that claim was denied by the Department of Labor Deputy Commissioner on January 30, 1989, on the grounds that claimant did not have pneumoconiosis from which he was totally disabled. (DX 1). Claimant filed a second claim for benefits on August 8, 1990. That claim was denied after a hearing before Administrative Law Judge Mollie W. Neal on December 28, 1992. Judge Neal found Claimant had failed to establish the presence of pneumoconiosis. Accordingly, she denied the claim for benefits.(DX 2). There is no record of appeal of that decision and, thus, the prior denial by Judge Neal was final. On July 9, 1997, Claimant filed his third claim for benefits. That claim was denied by the District Director on December 19, 1997. The District Director found the evidence did not establish the presence of pneumoconiosis, that such pneumoconiosis arose out of coal mine employment, or total disability due to pneumoconiosis. Claimant then submitted a timely request for modification on February 29, 1998 and submitted an additional medical report. After considering the evidence, the district director issued a proposed decision and order denying the request for modification on April 20, 1998. Claimant did not appeal that decision nor request a formal hearing on the denial of the request for modification. Thus, the prior denial of December 19, 1997 and the denial of request for modification on April 20, 1998 are final.(DX 2).

On September 9, 2002, the Department of Labor issued a schedule for submission of additional evidence on this fourth claim for benefits and stated a preliminary conclusion had been made that the claimant would not be entitled to benefits. (DX 25). On March 6, 2003, the district director issued a proposed decision and order denying benefits finding the evidence does not show that the miner is totally disabled by pneumoconiosis. (DX 27). The claimant, through counsel, requested a formal hearing on March 19, 2003. (DX 28).

The case was referred to the Office of Administrative Law Judges by the Director for a formal hearing on June 17, 2003. I was assigned the case on September 11, 2003. (DX 32). On January 12, 2004, I held a hearing in Pittsburgh, Pennsylvania, at which the claimant and employer were represented by counsel. No appearance was entered for the Director, Office of Workman Compensation Programs (OWCP). The parties were afforded the full opportunity to

present evidence and argument. Claimant's exhibit ("CX") 1-9[2], Employer's exhibits ("EX") 1-10 and Director's exhibits ("DX") 1-34 were admitted into the record without objection. The abbreviation "TR" denotes transcript of the hearing. Post-hearing, the employer submitted a closing brief.

ISSUES

I. Whether the miner has pneumoconiosis as defined by the Act and the Regulations?

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner is totally disabled?

IV. Whether the miner's disability is due to pneumoconiosis?

V. Whether Claimant has demonstrated one of the applicable conditions of entitlement has changed since the prior denial of December 19, 1997 and the denial of the request for modification on April 20, 1998?

FINDINGS OF FACT

I. Background

A. Coal Miner and Responsible Operator

Employer has stipulated that Claimant was employed as a miner after December 31, 1969 for 39 years in coal mine employment with the most recent coal mine employment being with the named responsible operator. Employer's stipulations are well supported by the record. (DX 7-9). Accordingly, I find Claimant has established 39 years of coal mine employment. I further find the evidence supports Employer's stipulation that it is properly identified as the responsible operator.

B. Date of Filing

The claimant filed this fourth, or duplicate claim for benefits under the Act on April 5, 2002. (DX 4). None of the Act's filing time limitations are applicable; thus, the claim was timely filed.

[2] Claimant's Exhibits as submitted were relabeled at the hearing after two x-ray reports were withdrawn prior to the hearing.

C. Dependents

The matter was not contested and I find the claimant has one dependent for purposes of augmentation of benefits under the Act, his wife, Lois Irene Snyder whom he married on September 29, 1944. (DX 1, 2, 4; TR 14).

E. Personal, Employment and Smoking History

The claimant was born on October 26, 1926, and has a ninth-grade education. (DX 4). At the hearing, it was stipulated he worked in the coal mines for at least 39 years. Claimant testified he worked last in coal mine employment for Canterbury Coal Company as a shuttle car driver. It was difficult for him to perform this job because of a back injury, however, his co-workers helped him with the most difficult work. Earlier he had worked as a scale man outside the mine, and he had also worked inside the mine as a general laborer and on maintenance. (DX 15-18). In 1984, when the mine shut down, Claimant ceased coal mine employment. (TR 18, 25).

Mr. Chemelli testified he is treated by physicians at the Veteran's Administration hospital including Dr. Bumbalo and Dr. Maleny. His family physician is Dr. Fox. He does not take any medications for his breathing problems because they made him feel sick. (TR 22-24). Currently, he is short of breath and his shortness of breath has worsened over the years. Claimant testified that he smoked about a pack of cigarettes a week from 1950 through 1963. (TR 22).

II. *Medical Evidence*

I incorporate by reference the summary of evidence contained in Judge Mollie Neal's Decision and Order Denying Benefits. (DX 2, pgs. 4 - 10).The following is a summary of the evidence submitted since the final denial of the miner's second prior claim. Because the miner did not have a formal hearing on his third claim, the medical evidence submitted with that claim is included below.

A. Chest X-rays[3]

There were twelve readings of four X-rays, taken on August 18, 1997, March 7, 2002, June 13, 2002, and September 11, 2003. All of the readings are properly classified for pneumoconiosis, pursuant to 20 C.F.R. § 718.102(b), except for the quality reading made by Dr. Duncan of the June 13, 2002 x-ray film[4]. Four of the readings are positive, one by Dr. Kearney, a board certified radiologist, and three by Dr, Harron, who is Board-certified in radiology and a B-reader.[5] Seven of the readings are negative, by Drs. Schaaf, and Boron, physicians, and by

[3] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102(e)(effective Jan. 19, 2001).

[4] ILO-UICC/Cincinnati classification of Pneumoconiosis – The most widely used system for the classification and interpretation of X-rays for the disease pneumoconiosis. This classification scheme was originally devised by the International Labor Organization (ILO) in 1958 and refined by the International Union Against Cancer (UICQ) in 1964. The scheme identifies six categories of pneumoconiosis based on type, profusion, and extent of opacities in the lungs.

[5] *LaBelle Processing Co. v. Swarrow,* 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. "A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading X-rays for pneumoconiosis by passing annually an

Drs. Navani, Pendergrass, Abraham, and Pickerill, all of whom are either B-readers, Board-certified in radiology, or both.

Exh. #	Dates 1. x-ray 2. read	Physician	Qualific-ations	Quality	Classif-ication	Interpretation or Impression
DX 2	08/18/97 08/21/97	Kearney	BCR	1	1/1 s, s	None listed
DX 2	08/18/97 09/02/97	Navani	B, BCR	3	None listed	Film completely negative
DX 14	03/07/02 03/07/02	Schaaf	BCP	Not stated	0/1 s, t	Few scattered linear streaky densities at the lung bases, only 2 of 6 zones involved
DX 17	03/07/02 09/12/02	Pendergrass	B, BCR	2	None listed	Film completely negative
CX 4	03/07/02 03/26/03	Harron	BCR	3	1/0 s, p	Opacities all six lung zones, thickening of the interlobar fissure
DX 11	06/13/02 06/24/02	Boron		1	0/0 p, p	Emphysema
DX 11	06/13/02 07/25/02	Duncan	B, BCR	2	Quality reading only	Emphysema
DX 18	06/13/02 09/13/02	Pendergrass	B, BCR	1	None listed	Film completely negative
CX 3	06/13/02 01/20/03	Harron	BCR	1	1/0 p, s	Opacities all six lung zones; blebs; rule out cancer right lower zone and left lower zone.
EX 1	09/11/03 09/11/03	Pickerill	B, BCP	1	0/0	Kerley lines, base; vague infiltrative process, right lung, probably chronic fibrotic basis, should be correlated with earlier examinations, if available.

examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to X-ray readings performed by "B-readers." *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 f.3d 1273, 1276 n. 2 (7th Cir. 1993)."

Exh. #	Dates 1. x-ray 2. read	Physician	Qualific-ations	Quality	Classif-ication	Interpretation or Impression
EX 1	09/11/03 09/12/03	Abrahams	B, BCR	1	No pneumo-coniosis	Vague interstitial density, right lung, appears chronic and fibrotic, but should be compared with earlier studies, if available.
CX 9	09/11/03 12/21/03	Harron	BCR	1	1/1 s, p	Opacities all six zones; blebs, emphysema and thickening of the interlobar fissure.

* A- A-reader; B- B-reader; BCR- Board-Certified Radiologist; BCP-Board-Certified Pulmonologist; BCI= Board-Certified Internal Medicine. Readers who are board-certified radiologists and/ or B-readers are classified as the most qualified. B-readers need not be radiologists.

** The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp.*, 6 B.L.R. 1-307 (1983); *Billings v. Harlan #4 Coal Co.*, B.R.B. No. 94-3721 (June 19, 1997) (unpub). If no categories are chosen in box 2B of the x-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.

B. CT Scans

The record contains the results of three CT scans read by physicians whose credentials are unknown. On a CT scan taken on April 24, 1995, Dr. H. Eisen reported generalized centrilobular emphysema and pulmonary fibrosis, moderate to severe in the lower lobes. Dr. Eisen also stated no pneumoconiosis was identified. (EX 5). On a CT scan taken on April 4, 1997, Dr. B. Kart reported centrilobular emphysema in all lobes and a minimal amount of interstitial fibrosis and linear fibrosis. Dr. Kart also reported no evidence of pneumoconiosis (EX 3). Finally, on a CT scan taken on January 25, 2002, Dr. Miller reported panlobular emphysema in both lungs with minimal basilar fibrosis. Dr. Miller stated there was no evidence of nodular effusion or focal pulmonary opacity (EX 6).

A CT scan falls into the "other means" category of 20 C.F.R. § 718.304(c) rather than being considered an X-ray under § 718.304(a). A CT scan is "computed tomography scan or computer aided tomography scan. Computed tomography involves the recording of 'slices' of the body with an x-ray scanner (CT scanner). These records are then integrated by computer to give a cross-sectional image. The technique produces an image of structures at a particular depth within the body, brining them into sharp focus while deliberately blurring structures at other depths. *See,* THE BANTAM MEDICAL DICTIONARY, 96, 437 (Rev. Ed. 1990)." *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991). In *Consolidation Coal C. v. Director, OWCP [Stein]*, ___ F.3d ___, 22 B.L.R. 2-409, 2002 WL 1363785 (7th Cir. June 25, 2002), the Court rejected the employer's argument that a negative CT is conclusive evidence the

miner does not have pneumoconiosis. The DOL has rejected such a view. Nor need a negative CT be given controlling weight because the statutory definition of "pneumoconiosis" encompasses a broader spectrum of diseases than those pathological conditions which can be detected by clinical test such as X-rays and CT scans.

C. Pulmonary Function Studies[6]

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV). For a miner of the claimant's height of 68.5 inches, § 718.204(b)(2)(i) requires an FEV_1 equal to or less than 1.81 for a male 68 years of age.[7] If such an FEV_1 is shown, there must be in addition, an FVC equal to or less than 2.33; or an MVV equal to or less than 74; or a ratio equal to or less than 55% when the results of the FEV_1 tests are divided by the results of the FVC test. Qualifying values for other ages and heights are as depicted in the table below. The FEV_1/FVC ratio requirement remains constant.

Physician Date Exh.#	**Age Height[i]**	**FEV_1**	**MVV**	**FVV**	**Tracings***	**Compre-hension Coopera-tion**	**Quali-fy** Con-form ***	**Dr.'s Impression**
Boota 05/04/95 EX 3	68 69"	2.91 2.60	-- --	4.46 4.62	No	not listed	No** No***	
Wodzinski 08/18/97 DX 2	70 69"	2.22 2.60+	93 106+	4.11 4.51+	yes yes	good/good	No** Yes***	none listed
Schaaf 03/07/02 DX 16	75 68.5"	2.03	71	4.13	Yes	best effort	No** Yes***	No bronchodilator used, causes nausea. Severe obstructive lung disease

[6] § 718.103(a)(Effective for tests conducted after Jan. 19, 2001 (See 718.101(b)), provides: "Any report of pulmonary function tests submitted in connection with a claim for benefits shall record the results of flow versus volume (flow-volume loop)." 65 Fed. Reg. 80047 (Dec. 20, 2000). In the case of a deceased miner, where no pulmonary function test are in substantial compliance with paragraphs (a) and (b) and Appendix B, noncomplying tests may form the basis for a finding if, in the opinion of the adjudication officer, the tests demonstrate technically valid results obtained with good cooperation of the miner. 20 C.F.R. § 718.103(c).

[7] The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are "qualifying." *Toler v. Eastern Associated Coal Co.*, 42 F.3d 3 (4th cir. 1995). I find the miner is 68.5" here, his median reported height.

Physician Date Exh.#	Age Height[i]	FEV_1	MVV	FVV	Tracings*	Compre-hension Coopera-tion	Quali-fy** Con-form ***	Dr.'s Impression
Illuzzi 06/13/02 DX 11	75 69"	1.88	--	3.36	Yes	good/good	Yes** Yes***	Moderate expiratory airflow obstruction; no bronchodilators used; MVV mildly decreased; no evidence significant restrictive lung disease; flow volume loop compatible with moderate obstructive disease; in conclusion, moderate obstructive airway disease
Pickerill 09/11/03 Ex 1	76 68"	1.92 2.25+	-- --	4.19 4.35+	yes yes	good/good	Yes** Yes***	Moderate obstructive defect but no restrictive defect; 16% improvement with bronchodilators suggest bronchial asthma; lung volumes showed hyperinflation due to the obstructive defect; single breath carbon monoxide diffusion capacity was moderately decreased, flow volume tracings confirmed obstructive defect.

* A Judge may infer, in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-83 (1984).
** A "**qualifying"** pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.
*** A study "**conforms**" if it complies with applicable quality standards (found in 20 C.F.R. § 718.103. (*see Old Ben Coal Co. v. Battram*, 7 F.3d. 1273, 1276 (7th Cir. 1993)). A judge may infer, in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).
+ Post-bronchodilator testing

Appendix B (Effective Jan. 19, 2001) states "(2) the administration of pulmonary function tests shall conform to the following criteria: (i) Tests shall not be performed during or soon after an acute respiratory illness…"
Appendix B (Effective Jan. 19, 2001), (2)(ii)(G): Effort is deemed "unacceptable" when the subject "[H]as an excessive variability between the three acceptable curves. The variation between the two largest FEV_1'S of the three acceptable tracings should not exceed 5 percent of the largest FEV_1 or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve the degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test." (Emphasis added).

C. Arterial Blood Gas Studies[8]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date Ex.#	Physician	pCO_2	PO_2	Qualify	Physician Impression
9/11/97 DX 2	Wodzinski	36.2 32.3 *	82.0 96.8 *	No No	
06/13/02 DX 11	Illuzzi	33.0 31.0 *	70.0 78.0 *	No No	
09/11/03 EX 1	Pickerill	32.0 34.0 *	79.0 73.0 *	No No	

*Results after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b). Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respiratory or cardiac illness."

D. Physicians' Reports

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(A)(4). Where total disability cannot be established, under 20 C.F.R. § 718.204(b)(2)(i) through (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Dr. T. Bumbalo, III, whose credentials are not in the record, stated on June 26, 1997, he had treated the miner for one and one-half years at the Veteran's Administration Medical Center's pulmonary clinic for shortness of breath on exertion. Dr. Bumbalo stated the shortness of breath was due to emphysema and pulmonary fibrosis due to coal mine employment. On chest x-ray, the miner's lungs showed fibrotic changes and areas of emphysema. CT scan showed a diffuse emphysema and left lower lung field fibrosis. Dr. Bumbalo reported pulmonary function study results demonstrated a mild obstructive pattern with a response to bronchodilators. Dr. Bumbalo stated there was no hereditary, medical or cardiac basis for these symptoms. He noted the miner had a very light and short smoking history but an extensive and

[8] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.
20 C.F.R. §718.204(b)(2) permits the use of such studies to establish "total disability." It provides: In the absence of contrary probative evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii), or (iv) of this section shall establish a miner's total disability:…
(2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part…

severe history of exposure to coal mine dust. In light of the positive findings of emphysema, pulmonary fibrosis and abnormal pulmonary function study results and in light of the lack of other medical conditions, Dr. Bumbalo concluded the miner's symptoms and disability are caused by the abnormal pulmonary findings which he stated are due to the miner's coal mine employment. (DX 2).

The miner was examined August 18, 1997 at the request of the Department of Labor by Dr. S. Wodzinski, whose credentials are not of record. (DX 2) The claimant reported attacks of wheezing, chronic bronchitis and arthritis. Smoking was reported as 1 pack of cigarettes per week from 1950 through 1963. Symptoms included sputum, wheezing, dypsnea, cough, and hemoptysis. The miner reported taking motrin daily. Dr. Wodzinski reported lung equal in expansion on inspection, normal on palpation, resonant to percussion and clear with no wheezes on forced expiration on auscultation of the chest and lungs. Dr. Wodzinski also reported chest showed x-ray evidence of pulmonary fibrosis, 1/1, pulmonary function study showed mild obstructive lung disease, arterial blood gas studies were normal and electrocardiogram testing showed no ischemia or infarct. On pulmonary stress test, Dr. Wodzinski reported Claimant demonstrated a mild exercise impairment due to deconditioning. Dr. Wodzinski diagnosed mild obstructive lung disease and pulmonary function study and he stated he could not tell if simple coal worker's pneumoconiosis was present since he had no work history. Likewise, he stated he could not determine whether any of the miner's impairment is due to his last coal mine employment since the miner did not provide his work history. Dr. Wodzinski stated the miner's lung disease causes a minor role in his impairment (DX 2). On October 16, 1997, Dr. Wodzinski stated that in light of the negative x-ray reading by a B-reader, he concluded the miner does not have coal worker's pneumoconiosis. He also stated the miner is not totally disabled but he does have a mild abnormality on pulmonary function study and pulmonary stress testing. (DX 2, EX 2).

In a letter to Dr. Fox, the miner's treating physician, dated February 5, 1998, Dr. S. Jethnalani stated he had examined the miner on referral for shortness of breath. Dr. Jethnalani noted the miner's coal mine employment history and smoking history. In addition, he stated the miner had rheumatic fever as a service man with no history of significant coronary or cardiac disease thereafter. In 1995, and echocardiogram showed no significant valvular disease and normal CV function. Electrocardiogram testing showed left ventricular hypertrophy. On physical examination, Dr. Jethnalani stated the miner had decreased breath sounds on auscultation with no wheezes or crackles. On chest x-ray, Dr. Jethnalani reported mild hyperinflation and mild interstitial fibrosis in the lower lung zones. Pulmonary test results from August, 1997 showed significant improvement in airflow after the use of bronchodilators. Based on the miner's history, physical examination findings and laboratory test results, Dr. Jethnalani concluded the miner has simple pneumoconiosis due to coal mine employment. The mild to moderate impairment demonstrated on pulmonary tests is most likely due to coal mine employment, especially noting the remote and insignificant smoking history. (DX 2).

Medical records from the Veteran's Hospital indicate the miner was treated for rheumatic fever during the war and he has constant muscle pain which has been treated with non-steroidal anti-inflammatory medications two to three times a year since then. In treatment records from October, 1996, Dr. Bumbalo diagnosed pneumoconiosis. In January, 1997, Dr. Bumbalo stated

that a diagnosis of pneumoconiosis as opposed to idiopathic pulmonary fibrosis was more probable considering the miner's prior coal mine employment history. In June, 1997, he diagnosed mild to moderate emphysema based on CT scan results and he noted moderate defect on pulmonary function study. Dr. Bumbalo stated the findings on the chest CT scan were consistent with pneumoconiosis. In February, 1998, Dr. Atwood noted the prior diagnosis of possible coal worker's pneumoconiosis and he stated the CT scan showed only extremely mild to minimal fibrosis in the right base as well as centra-lobular emphysema. Dr. Atwood concluded the miner had mild emphysema with an airflow obstruction on pulmonary function study and a decrease in the diffusing capacity. Dr. Atwood stated further the lung disease was probably due to coal mine employment history in light of the minimal smoking history, but the miner was not disabled by his pulmonary condition. More recently, after a January 4, 2000 visit, Dr. Atwood, chief of the pulmonary section, stated the chest x-ray and CT scans showed lower lobe fibrotic changes, but no upper lobe small opacities consistent with coal worker's pneumoconiosis. Dr. Atwood noted previous pulmonary function studies showed a mild airflow obstruction with a response to bronchodilators. He concluded most recently that the miner had no evidence of coal worker's pneumoconiosis, probable adult onset of asthma, and mild pulmonary parenchymal scarring possibly related to coal mine employment (EX 3).

Dr. J. Schaaf, who is a Board certified pulmonologist, examined Claimant on March 7, 2002. His examination report, based upon his examination of the claimant, notes 42 years of coal mine employment and a 13-year smoking history of a pack a week. (DX 14). Dr. Schaaf described the claimant's symptoms as shortness of breath during activities of daily living with daily wheezing and daily cough. On chest x-ray, Dr. Schaaf reported only minor changes. Based on examination findings and pulmonary testing, Dr. Schaaf stated the physiologic picture is of an obstructive airways disease with minor chest x-ray changes. (DX 14). On March 18, 2002, after reviewing additional record, Dr. Schaaf modified his earlier report. He stated the CT scans of 1996 and 1997 showed changes consistent with densities he saw on chest x-ray. Therefore, Dr. Schaaf concluded the miner has a positive x-ray. Based on the positive x-ray and the miner's coal mine employment history, Dr. Schaaf concluded it was his opinion Claimant's breathlessness is due to fibrosis and emphysema which has caused severe obstructive airways disease and the underlying etiology is Claimant's coal mine employment (DX 15). More recently, on June 3, 2002, Dr. Schaaf stated after reviewing cardiac test results and the consultation report of Dr. Mark Milchak, there is no evidence of any cardiac dysfunction causing the breathlessness and his opinion, as set forth in the prior reports, remains unchanged. (CX 7).

At a deposition taken on December 12, 2003, Dr. Schaaf explained his reports in greater detail. He stated there is no evidence of rheumatic fever or any cardiac abnormality resulting from the rheumatic fever Claimant had in 1946. Dr. Schaaf noted the report of Dr. Tuteur (relied upon by Judge Neal in the prior denial) is the only report which concludes Claimant's pulmonary dysfunction is due to rheumatic fever or the residuals of the earlier rheumatic fever. Dr. Schaaf reiterated his written finding that Claimant has a severe obstructive airways disease as demonstrated by his pulmonary function study results. He stated Claimant does not have asthma since pulmonary function study results do not show reversibility. Dr. Schaaf also stated the wheezing reported is chronic and not episodic. Dr. Schaaf stated Claimant's pulmonary function study results deteriorated over time and the blood gas study results deteriorated over time. On cross-examination, Dr. Schaaf explained he diagnosed dypsnea based on the pulmonary function

study results and then on the basis of the positive chest x-ray and CT scan results, he concluded the miner's dypsnea is due to coal dust exposure. (DX 13). On January 19, 2004, Dr. Schaaf reviewed the report of Dr. Fino, set forth below. Dr. Schaaf stated he disagreed with Dr. Fino that pulmonary function study results are reversible. Rather, he noted they are variable which is consistent with an obstructive airway disease (CX 15).

Dr. A. Illuzzi, whose qualifications are not in the record, examined Claimant on behalf of the Department of Labor. His examination report, based upon his examination of the claimant, on June 13, 2002, notes 31 years of coal mine employment and a 13-year smoking history of a pack of cigarettes a week. (DX 11). Dr. Illuzzi described the claimant's symptoms as attacks of wheezing, arthritis, heart disease and allergies. In addition, he noted normal findings on palpation, percussion and auscultation of Claimant's chest and lungs. Dr. Illuzzi conducted tests, including chest x-ray, pulmonary function study and blood gas study. Dr. Illuzzi concluded Claimant has a moderate chronic obstructive pulmonary disease and ischemic heart disease. Dr. Illuzzi stated Claimant's pulmonary disease is due to coal mine dust, smoke from his moderate smoking history and fume exposure. Dr. Illuzzi stated Claimant is severely impaired and his lung disease is a major part of his impairment. On cardiac stress testing, Dr. Illuzzi reported extremely poor exercise tolerance, subjective symptoms which are consistent with angina pectoris, and evidence of ventricular irritability by PACS and PVCS in the recovery phase (DX 11). On August 7, 2002, Dr. Illuzzi stated based on his examination on June13, 2003 and the test results, Claimant has evidence of a moderate obstructive airways disease. He stated Claimant is severely impaired for several reasons, his age, the severe decrease in his exercise tolerance and ability, the probably underlying ischemic heart disease and angina pectoris. Dr. Illuzzi concluded Claimant is impaired by both his moderate lung disease and the possible underlying ischemic heart disease. (DX 13).

On October 14, 2002, Dr. D. Fox, board certified in family medicine, wrote a letter. She stated she has treated Claimant for many years and he has had normal cardiac function with no audible heart murmur and normal results on electrocardiogram testing and echocardiogram testing in 1995. Dr. Fox conclude Claimant has never had rheumatic fever. (CX 1). An undated cardiac stress scan found small fixed anterolateral defect near the apex with no reversible lesions. (CX 6). A consultation report prepared by Dr. M. Milchak on November 7, 2002, and written to Dr. Fox, however, noted Claimant's history of rheumatic fever as a teen. Dr. Milchak reported normal LV function with no significant valvular heart disease. Dr. Milchak also reported a mild mitral regurgitation which was an unlikely cause of Claimant's dypsnea. A small defect on a thallium scan was not clinically significant. Dr. Milchak concluded that it was unlikely the current symptoms of dypsnea are related to valvular disease or coronary artery disease (CX 8). Treatment records from Dr. Fox include a record of a hospital emergency room visit on May 15, 2003 for transient ischemic attack. On a November 10, 2003 check-up report, Dr. Fox noted Claimant had reports from two pulmonologists, one of which concluded he had black lung and one of which concluded he had chronic obstructive pulmonary disease/asthma. Dr. Fox wrote on this November, 2003 report she had declined to write a report for these proceedings since both reports from the pulmonologists included excellent reasons for the diagnosis and good data to support their conclusions. (EX 9).

Dr. R. Pickerill is a B-reader and is Board-certified in pulmonary medicine. His examination, based upon his examination of the claimant, on September 11, 2003, notes 39 1/2

years of coal mine employment and a 13-year smoking history of one pack of cigarettes a week. (EX 1). Dr. Pickerill described the claimant's symptoms as chronic shortness of breath with exertion, intermittent nocturnal wheezing, chronic productive cough, and no chest pains, hemoptysis, anorexia, weight loss, or edema of the legs. Dr. Pickerill reported normal results on inspection and auscultation of the chest and lungs. Dr. Pickerill also reviewed extensive medical records. Based on arterial blood gases, a pulmonary function study which showed improvement with bronchodilators and hyperinflation due to obstructive defect on lung volumes, and a negative chest x-ray by both himself and Dr. Abrahams, and his review of the medical records, Dr. Pickerill diagnosed: 1) no radiographic evidence of coal worker's pneumoconiosis by my own reading; 2) moderate chronic obstructive pulmonary disease, most likely due to chronic obstructive bronchial asthma; 3) aortic and mitral valvular regurgitation; and 4) chronic arthritis of the knees and spine. Dr. Pickerill concluded Claimant has a partial functional respiratory impairment which Dr. Pickerill attributed to moderate obstructive lung disease. Dr. Pickerill opined that the claimant's pulmonary condition, the moderate obstructive lung disease, was primarily due to chronic bronchial asthma, which has not been treated with medications since 1995. Dr. Pickerill noted significant improvement in the FEV-1 results has been documented by multiple pulmonary function studies, which is consistent with bronchial asthma. The lung function tests in December, 1988, and October, 1989, three to four years after he left coal mine employment, suggest sufficient pulmonary reserve to do the last job in coal mine employment. The deterioration in his lung function since that time is most likely due to untreated bronchial asthma rather than progressive coal worker's pneumoconiosis. From a general medical standpoint, Dr. Pickerill stated the miner should be treated with long-acting beta-agonist drugs and inhaled steroids for chronic bronchial asthma and then have follow-up pulmonary function tests. (EX 1).

Dr. Pickerill reiterated many of his findings at a deposition taken on January 8, 2004. Dr. Pickerill explained in greater detail that the pattern of pulmonary function study results was particularly important in diagnosing chronic bronchial asthma. Dr. Pickerill stated this diagnosis was based on the history of the miner's symptoms, the airway obstruction on pulmonary function studies which improved with the use of bronchodilators, the pulmonary function studies which showed decrease on bronchial hyperactivity challenge tests, the findings on physical examination, and the responses by the miner to treatment. Dr. Pickerill also noted the variability shown by the miner on pulmonary function study, lack of a significant smoking history, the findings on chest x-ray of no pneumoconiosis and the evidence of hyperinflation on lung volume testing are all consistent with an obstructive lung disease such as asthma. Dr. Pickerill also stated the improvements of about 12% are diagnostic of asthma, but he clarified further the pattern of test results is important and the improvement demonstrated by this patient who is being diagnosed with asthma in his 60's will be different from the improvement demonstrated by testing on a patient diagnosed much younger. Dr. Pickerill explained it is his opinion that the bronchial asthma is not related to Claimant's coal mine employment since his pulmonary function study results were normal three years after he ceased coal mine employment. Dr. Pickerill did state, however, that with Claimant's long coal mine employment history, he could not exclude a minor contribution to Claimant's obstructive lung disease from the coal mine employment and dust exposure. He explained further, however, that the progression in the lung disease is not related to Claimant's coal mine employment. Dr. Pickerill agreed clearly that Claimant's cardiac status is not playing any role in his pulmonary symptamatology. (EX 2).

Dr. G. Fino is a B-reader and is Board-certified in pulmonary medicine. His consultation report, based upon his review of the medical records of the claimant, dated December 17, 2003, notes 39 to 42 years of coal mine employment in various medical reports and a 13-year smoking history of a pack of cigarettes a week. (EX 8). Dr. Fino stated the pulmonary function study results and blood gas study results showed a mild obstructive ventilatory impairment which was reversible in 2002 in the absence of any oxygen impairment. In September, 2003, the pulmonary function study showed a similar degree of obstruction on FEV-1 with a reduction in diffusing capacity which suggests some pulmonary emphysema is present. Dr. Fino stated it was his opinion Claimant has had bronchial asthma, noting significant reversibility on pulmonary testing between 1988 and 1991. During this time, he did not have a pulmonary impairment which would have prevented him from performing his usual coal mine employment. The worsening FEV-1 since 1993 is consistent with bronchial asthma. The FEV-1, however, remains reversible. However, the value demonstrated on the pulmonary function study of September, 2002, shows the bronchial asthma would prevent Claimant from performing his usual coal mine employment. Dr. Fino stated, however, based on the test results from 1988 through 1997, Claimant was not disabled during this time period. The disability that is present developed twelve years after Claimant left coal mine employment, a pattern which is consistent with bronchial asthma. Since emphysema was described on CT scan reports, and since the miner had no significant smoking history, Dr. Fino concluded that coal mine dust may have contributed to some emphysema. However, the emphysema described on the CT scan of April, 1997, was not disabling since the abnormality shown on lung function fourth months later was a mild reversible obstructive abnormality. Thus, Dr. Fino concluded: 1) there is insufficient objective medical evidence to justify a diagnosis of coal worker's pneumoconiosis; 2) there is a mild respiratory impairment present; and 3) from a respiratory standpoint, Claimant is disabled from returning to his last mining job or a job requiring similar effort. (EX 8).

III. Conclusions of Law

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP v. Mangifest*, 826 F.2d 1318, 1320 (3rd Cr. 1987).

Since this is the claimant's fourth claim for benefits, and it was filed on or after January 19, 2001, it must be adjudicated under the new regulations.[9] Claimant must initially demonstrate

[9] Section 725.309(d)(For duplicate claims filed on or after Jan. 19, 2001)(65 Fed. Reg. 80057 & 80067):

(d) If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part (see § 725.502(a)(2)), the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance

that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. 20 C.F.R. 725.309(d). As a threshold matter, all factors essential to entitlement were previously adjudicated against the claimant in the 1997 denial: that he suffers from pneumoconiosis caused by coal mine employment, or that he is totally disabled due to pneumoconiosis. In order to establish entitlement to benefits, he must prove that pneumoconiosis is a "substantial contributor" to his total disability. *See Bonessa v. U.S. Steel Corp.,* 884 F.2d 726, 734 (3rd Cir. 1989).

B. Existence of Pneumoconiosis and Cause of Pneumoconiosis

30 U.S.C. § 902(b) and 20 C.F.R. § 718.201 define pneumoconiosis as a "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment."[10] The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201.[11]

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with the provisions of subpart E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see Sections 725.202(d)(miner), 725.212(spouse), 725.218(child), and 725.222(parent, brother or sister)) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:

(1) any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.

(2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of this subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.

(3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement. A subsequent claim filed by a surviving spouse, child, parent, brother, or sister shall be denied unless the applicable conditions of entitlement in such claim include at least one condition unrelated to the miner's physical condition at the time of his death.

(4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue (see § 725.463), shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

(5) In any case in which a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the order denying the prior claim became final.

[10] Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP,* 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358, 1364 (4th Cir. 1996)(*en banc*); *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-15 (3rd Cir. 1995).

[11] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers'

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[12] Thus, "pneumoconiosis", as defined by the Act, has a much broader legal meaning than does the medical definition. "…[T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing, Rose v. Clinchfield Coal Co.*, 614 F.2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *see* § 718.201(a)(2).

The claimant has the burden of proving the existence of pneumoconiosis. The regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[13] 20 C.F.R. § 718.202(a)(4).

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pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.
(Emphasis added).

[12] The definition of pneumoconiosis, in 20 C.F.R. section 718.201, does not contain a requirement that "coal dust specific diseases …attain the status of an "impairment" to be so classified. The definition is satisfied "whenever one of these diseases is present in the miner at a detectable level; whether or not the particular disease exists to such an extent as to become compensable is a separate question." Moreover, the legal definition of pneumoconiosis "encompasses a wide variety of conditions; among those are diseases whose etiology is not the inhalation of coal dust, but whose respiratory and pulmonary symptomatology have nevertheless been made worse by coal dust exposure. *See, e.g., Warth*, 60 F.3d at 175." *Clinchfield Coal v. Fuller*, 180 F.3d 622 (4th Cir. June 25, 1999) at 625.

[13] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel,* 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

The Third Circuit has held that the four methods of establishing the existence of the disease, provided in 20 C.F.R. § 718.202, are not to be considered in the disjunctive; that is, relevant evidence developed under the four methods of proof are to be considered together to determine whether a claimant has pneumoconiosis. *Penn Allegheny Coal Co. v. Williams & Director, OWCP*, 114 F.3d 22 (3rd Cir. June 3, 1997) *Citing* 30 U.S.C. § 923(b) and *Kertesz v. Cresent Hills Coal Co.*, 788 F.2d 158 (3d Cir. 1986).

The claimant cannot establish pneumoconiosis pursuant to subsection 718.202(a)(2) because there is no biopsy evidence in the record. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable to a living miner's claim field after January 1, 1982, with no evidence of complicated pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence. 20 C.F.R. § 718.202(a)(1). "[W]here two or more X-ray reports are in conflict, in evaluating such X-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." *Id.; Dixon v. North Camp Coal Co*., 8 B.L.R. 1-344 (1985)." Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n.5 (1985).

In the x-ray evidence submitted with the prior claim, the persuasive and credible x-ray readings were negative for pneumoconiosis, including readings by Board-certified radiologists and B-readers. As noted above, of the twelve newly submitted readings of four separate x-ray films, one is a reading for quality only, four are positive and seven are negative for pneumoconiosis. The positive readings by Drs. Harron and Schaaf, board certified radiologist or board certified pulmonologist and B-readers are comparable to the negative readings by Drs. Navani, Kearney, Pickerill and Abrahams, who are also highly qualified. As discussed below, however, the negative CT scans lend strong support to the negative x-ray readings. Accordingly, under the circumstances of this case, I find the negative x-ray readings outweigh the positive readings of record.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative X-ray. 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical pinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not

be considered sufficiently reasoned if the underlying objective medical data contradicts it.[14] *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Because of their various Board-certifications, B-reader status, and expertise, as noted above, I rank Drs. Schaaf, Pickerill and Fino as more qualified to assess Claimant's pulmonary condition. Dr. Fox was Mr. Chemelli's treating physician for "many" years and the treatment records from Drs. Bumbalo and Atwood indicate Mr. Chemelli was treated by physicians at the Veteran's Administration pulmonary clinic for at least four years. As such, the opinions of Drs. Fox, Bumbalo and Atwood will be considered under the criteria of section 718.104(d).[15]

[14] *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltor Coal Corp.*, 6 B.L.R. 1-1291 (1984)…" In *Cornett v. Benham Coal, Inc.,* 227 F.3d 569, Case No. 99-3469, 22 B.L.R. 2-107 (6th Cir. Sept. 7, 2000), the court held if a physician bases a finding of CWP only upon the miner's history of coal dust exposure and a positive X-ray, then the opinion should not count as a reasoned medical opinion, under 20 C.F.R. § 718.202(a)(4). (It also rejected Dr. Fino's opinion that the miner's affliction was due solely to smoking and not coal dust exposure because the PFS were not consistent with fibrosis, as would be expected in simple CWP. Fibrosis, while an element of medical CWP, is not a required element of legal CWP).

[15] § 718.104(d) Treating Physician (Jan. 19, 2001). In weighing the medical evidence of record relevant to whether the miner suffers, or suffered, from pneumoconiosis, whether the pneumoconiosis arose out of coal mine employment, and whether the miner is, or was totally disabled by pneumoconiosis or died due to pneumoconiosis, the adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into the record. Specifically, the adjudication officer shall take into consideration the following factors in weighing the opinion of the miner's treating physician:

(1) Nature of relationship. The opinion of a physician who has treated the miner for respiratory or pulmonary conditions is entitled to more weight than a physician who has treated the miner for non-respiratory conditions;

(2) Duration of relationship. The length of the treatment relationship demonstrates whether the physician has observed the miner long enough to obtain a superior understanding of his or her condition;

(3) Frequency of treatment. The frequency of physician-patient visits demonstrates whether the physician has observed the miner often enough to obtain a superior understanding of his or her condition; and

(4) Extent of treatment. The types of testing and examinations conducted during the treatment relationship demonstrate whether the physician has obtained superior and relevant information concerning the miner's condition.

(5) In the absence of contrary probative evidence, the adjudication office shall accept the statement of a physician with regard to the factors listed in paragraphs (d)(1) through (4) of this section. In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officers' decision to give that physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasoning and documentation, other relevant evidence and the record as a whole.

As a general rule, more weight is given to the most recent evidence because pneumoconiosis is a progressive and irreversible disease. *Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-166 (1983); and, *Call v. Director, OWCP*, 2 B.L.R. 1-146 (1979).[16] This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984).

On reviewing the medical opinion reports, I note all the physicians agree the miner has some obstructive pulmonary condition present. The physicians disagree, however, as to whether or not medical or legal pneumoconiosis is present. The results of CT lung scans were cited both in support of a diagnosis of pneumoconiosis and in support of a finding that pneumoconiosis was not present. On review of the plain language of the physicians who read the CT scans, however, I note that two physicians concluded specifically that changes of pneumoconiosis were not present and, on the January 25, 2002 CT scan, Dr. Miller stated there was no evidence of nodular effusion or focal pulmonary opacity. Although Dr. Schaaf and Dr. Bumbalo cited the changes on the CT scan results as supportive of their diagnosis of pneumoconiosis, I find the plain language of the CT scan reports which concluded pneumoconiosis is not identified or is not present does not support their conclusions. Rather, I find the CT lung scan reports supportive of the reports of Drs. Pickerill, Atwood and Fino that conclude medical pneumoconiosis is not present.

As noted above, however, the regulations also provide that pneumoconiosis may be established where any chronic lung disease or impairment and its sequelae arises out of coal mine employment. Thus, the agreement of the physicians that some chronic obstructive pulmonary condition is present must be further evaluated. Drs. Bumbalo, Jethnalani, Schaaf, and Illuzi all attribute the chronic obstructive changes to Claimant's coal mine employment. These physicians all note a minimal and remote smoking history in support of this conclusion. At his deposition, Dr. Schaaf disagreed that the changes present were due to asthma since he stated the pulmonary function study results do not show reversibility. Although he agreed some pulmonary function tests showed reversibility ranging form 10% to 16%, Dr. Schaaf stated the minimal reversibility required is 15% and one would expect reversibility of 25% to 30% if asthma is present.

In contrast, Drs. Atwood, Pickerill and Fino all conclude the miner's obstructive pulmonary condition is due to asthma. Dr. Atwood concluded adult onset asthma was present, Dr. Pickerill concluded chronic obstructive bronchial asthma was present and Dr. Fino concluded bronchial asthma was present. Dr. Fino supported his conclusion that the cause of Claimant's pulmonary condition was bronchial asthma by reviewing the pulmonary function study results. He noted the results from pulmonary function studies taken from 1988 through 1991 showed significant reversibility. Dr. Fino also stated the worsening FEV-1 values since 1993 are

[16] *Cranor v. Peabody Coal Co.*, 21 B.L.R. 1-201, BRB No. 97-1668 (Oct. 29, 1999) *on recon*. 22 B.L.R. 1-1 (Oct. 29, 1999)(*En Banc.*). In a case arising in the Sixth Circuit, the Board held it was proper for the judge to give greater weight to more recent evidence, as the Circuit has found CWP to be a "progressive and degenerative disease." *See also Abshire v. D & L Coal Co*. 22 B.L.R. 1-203 (2002), citing *Staton v. Norfolk & Western Railroad Co.*, 65 F.3d 55, 19 B.L.R. 2-271 (6th Cir. 1995); *Woodward v. Director, OWCP,* 991 F.2d 314, 17 B.L.R. 2-77 (6th Cir. 1993); *Edmiston v. F & R Coal Co.*, 14 B.L.R. 1-65 (1990); and, *Clark v. Karst-Robbin Coal Co*., 12 B.L.R. 10-149 (1989), the Board holds greater weight may be accorded to more recent X-ray evidence of record. In *Abshire*, the Board also recognized *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 11 B.L.R. 2-1 (1987) (CWP is a progressive disease).

consistent with bronchial asthma and he noted these values remain reversible. In addition, Dr. Fino stated the fact that Claimant was not disabled between 1988 and 1997 which supports a finding that the changes were due to asthma and not to coal dust exposure. The worsening of the obstructive abnormality twelve years after exposure to coal dust had ceased combined with the reversibility demonstrated on testing are all consistent with the development of bronchial asthma. Dr. Pickerill reached similar conclusions on review of the pattern of pulmonary function study results over many years. In addition, he relied upon several other factors, including the miner's history of symptoms, findings on physical examination, variability in pulmonary function study results and the findings on chest x-ray in support of his diagnosis of chronic bronchial asthma.

Dr. Fox, Claimant's treating physician, noted in November, 2003, the medical opinion reports reached contrary conclusions regarding the etiology of Claimant's pulmonary condition. Dr. Fox noted one report attributed his condition to black lung due to his prior coal mine employment while the other attributed it to chronic obstructive pulmonary disease and asthma. Dr. Fox stated these opinions were equally credible since both had excellent supportive data and were equally well reasoned. Dr. Fox's report, therefore, is not entitled to particular weight as a treating physician since she makes no specific finding on the presence or absence of pneumoconiosis, either medical or legal.

Dr. Bumbalo and Dr. Atwood reached opposite conclusions in their treatment of Claimant at the pulmonary clinic at the Veteran's Administration Hospital. I find Dr. Atwood's more recent conclusion that Claimant had probable adult onset of asthma and not pneumoconiosis persuasive in light of the more recent test results, including CT scans Dr. Atwood relied upon. I also note, however, Dr. Atwood also stated Claimant had mild pulmonary parenchymal scarring which was possible related to coal mine employment. Thus, Dr. Atwood's own reports are not entirely clear on whether or not Claimant has any pulmonary condition due to his prior coal mine employment.

On consideration of all of the medical reports, I find most persuasive the medical opinion reports of Drs. Pickerill and Fino. These physicians note specific changes on pulmonary function study and the history of those changes on these studies in support of their conclusions that Claimant's pulmonary condition is due to the development of bronchial asthma rather than any medical condition due to coal mine employment. These reports provide sufficient reasoning and documentation to outweigh the less persuasive report of treating physician Dr. Bumbalo. In addition, although Dr. Atwood's comments regarding the presence of mild pulmonary parenchymal possibly related to coal mine employment are not entirely clear, his conclusion as a treating physician that the miner has developed adult onset of asthma is consistent with the findings of Drs. Pickerill and Fino. While Dr. Schaaf stated a greater degree of reversibility on pulmonary function study results is required to diagnose asthma, I find his opinion is outweighed by the contrary opinions of Drs. Pickerill, Fino and Atwood who all conclude asthma is present. In particular, I note Dr. Pickerill explained why under the particular circumstances of this case a pattern of reversibility is more important than the actual percentage demonstrated. In light of the analysis by Drs. Pickerill and Fino, both pulmonary specialists, that Claimant demonstrated reversibility on pulmonary function studies taken from 1988 through 2002 and in light of their conclusions that this pattern of reversibility over this fourteen year period is consistent with asthma, I find Dr. Schaaf's statements are outweighed.

To summarize, the conclusions of Drs. Pickerill, Fino and Atwood that medical pneumoconiosis is not present outweigh the contrary medical opinion reports of record and these conclusions are well supported by the results of the CT scans included in the record. In addition, the conclusions of Drs. Pickerill, Fino and Atwood that the asthma present did not arise out of the miner's coal mine employment and, thus, is not legal pneumoconiosis also outweighs the contrary medical opinion reports of record and are well supported by the pattern of pulmonary function study results over time as discussed in greatest detail by Drs. Pickerill and Fino. Thus, after considering all the medical opinion reports and other medical evidence, I find the claimant has not met his burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994) *aff'g sub. nom. Greenwich Collieries v. Director, OWCP,* 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

Furthermore, I find that the evidence, when weighed together, is not sufficient to support a finding of the existence of coal workers' pneumoconiosis pursuant to § 718.202(a). As this element of entitlement was previously adjudicated against the claimant, I find that he has not proven this element of entitlement previously denied has changed since the denial of his prior claims.

C. Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R § 718.203(b). Since the miner had ten years or more of coal mine employment, the claimant would ordinarily receive the benefit of the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. However, in view of my finding that the existence of coal worker's pneumoconiosis has not been proven the issue is moot. Moreover, the presumption is rebutted by the medical opinion evidence discussed herein. Therefore, claimant has not established this element of entitlement has changed since the prior denial of his claims.

D. Total Disability

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b).[17] Section 718.204(b)(2)(i) through (b)(2)(iv) set forth criteria to establish total disability: (i) pulmonary function studies with qualifying values; (ii) blood gas studies with qualifying values; (iii) evidence that miner has pneumoconiosis and suffers from cor pulmonale with right-side congestive heart failure; (iv) reasoned medical opinions concluding the miner's

[17] § 718.204 (Effective Jan. 19, 2001). Total disability and disability causation defined; criteria for determining total disability and total disability due to pneumoconiosis, states: (a) General. Benefits are provided under the Act for or on behalf of miners who are totally disabled due to pneumoconiosis, or who were totally disabled due to pneumoconiosis at the time of death. For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease shall be considered in determining whether a miner is or was totally disabled due to pneumoconiosis.

respiratory or pulmonary condition prevents him from engaging in his usual coal mine employment; and lay testimony.[18] Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff'd on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(b)(2)(iii) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. Section 718.204(d) is not applicable because it only applies to a survivor's claim or deceased miners' claim in the absence of medical or other relevant evidence.

Section 718.204(b)(2)(i) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. More weight may be accorded to the results of a recent ventilatory study over those of an earlier study. *Coleman v. Ramey Coal Co.,* 18 B.L.R. 1-9 (1993). Since Claimant demonstrated qualifying values on the two most recent pulmonary function studies, I find Claimant has established total disability under the provisions of Section 718.204(b)(2)(i) on the two most recent pulmonary function studies.

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. Section 718.204(b)(2)(ii). Claimant's values on all the blood gas studies were non-qualifying. Therefore, I find Claimant has not established total disability under the provisions of Section 718.204(b)(2)(ii).

Finally, total disability may be demonstrated, under § 718.204(b)(2)(iv), if a physician, exercising reasoned medial judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition presents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable or gainful work. § 718.204(b). All the physicians agreed that Claimant is now totally disabled due to his pulmonary condition. Accordingly, I find Claimant has established total disability under Section 718.204(b)(2)(iv).

On consideration of all of the medical evidence, I find the medical opinion reports, as supported by the recent qualifying pulmonary function studies, are sufficient to establish total disability under Section 718.204(b)(2).

E. Cause of Total Disability

The revised regulation at 20 C.F.R. § 718.20(c)(1), requires a claimant establish his pneumoconiosis is a "substantially contributing cause" of his totally disabling respiratory or pulmonary disability. The January 19, 2001 changes to 20 C.F.R. § 718.204(c)(1)(i) and (ii),

[18] 20 C.F.R. § 718.204(d)(5)(living miner's statements or testimony insufficient alone to establish total disability).

adding the words "material" and "materially", results in "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability." For reasons set forth above, I accord greater weight to the opinions of Drs. Pickerill, Fino and Atwood who concluded the miner's pulmonary disability is due to the development of asthma which is not related to his prior coal mine employment. Therefore, Claimant has not established that pneumoconiosis, medical or legal, was a substantially contributing cause to this totally disabling respiratory or pulmonary impairment. Thus, I find there is not sufficient evidence linking coal workers' pneumoconiosis to his pulmonary or respiratory disability, and I find Claimant has not established that pneumoconiosis is a substantially contributing cause of any pulmonary or respiratory disability.[19]

Since Claimant has not established that he is totally disabled due to pneumoconiosis under Section 718.204, he has not established that applicable condition of entitlement has changed since it was previously adjudicated against him.

F. Attorney's Fees

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to the receipt of benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to claimant for representation services rendered to him in pursuit of his claim.

CONCLUSION

In conclusion, the claimant has not established that any of the applicable conditions of entitlement have changed since the prior denial. Thus, his claim must be denied on the basis of the prior denials pursuant to Section 725.309(d). However, has also failed to establish the presence of pneumoconiosis, that such pneumoconiosis arose out of coal mine employment or that he is totally disabled due to pneumoconiosis. Thus, the claimant is not entitled to benefits.

[19] Even if Dr. Fino's comment that the miner's coal mine dust exposure "may have" contributed to his emphysema is credited, the April 1997 CT showed it was not disabling, and Dr. Pickerill found only a "minor" contribution of coal mine dust exposure to his COPD. Dr. Atwood found the emphysema "mild." Thus, the emphysema constituted, at best, an inconsequential contribution to the miner's disability.

ORDER[20]

It is ordered that the claim of Leo A. Chemelli for benefits under the Black Lung Benefits Act is hereby DENIED.

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RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS (**Effective Jan. 19, 2001**): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e., at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.**[21]

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[20] § 725.478 Filing and service of decision and order (Change effective Jan. 19, 2001). Upon receipt of a decision and order by the DCMWC, the decision and order shall be considered to be filed in the office of the district director, and shall become effective on that date.

[21] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001). (d) Regardless of any defect in service, **actual receipt** of the decision is suffice to commence the 30-day period for requesting reconsideration or appealing the decision.